TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PROFESSIONAL EMERGENCY SERVICE

Respondent Name
TRAVELERS PROPERTY CASUALTY COMPANY

MFDR Tracking Number
M4-16-2878-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
May 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary:

Please find enclosed a copy of EcCare's electronic log of facsimile or email receipts or a signed copy of the daily selections mail log pertaining to the requirements for medical billing. . . .

EcCare submits this mail log, fax receipt, or email read receipt as evidence of timely submission . . .

Amount in Dispute: $790.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

For date of service 08-03-2016, attached please find the Explanation of Reimbursement dated 06-10-2016 reflecting payment to the Provider in the amount of $248.22. . . .

For date of service 08-19-2016, attached please find the Explanation of Reimbursement dated 06-17-2016 reflecting payment to the Provider in the amount of $513.50. . . .

Please also note that interest was not due on either payment as payment was issued within 60 days of receipt of the complete medical bill in accordance with Rule 134.130. . . . Although the Provider documents previous attempts to send the medical billing and related documentation to the Carrier, these attempts failed for the following reasons. First, the fax number which the Provider has listed for the Carrier is 877-840-7788. . . . That number does not belong to the Carrier. A Google search for that number reports it is the fax number for the South Carolina Department of Insurance. Second, the Provider's documentation was e-mailed to [the adjuster] . . . Although there is an adjuster with the Carrier by that name, that is not a valid e-mail address for her. The Carrier has no record of receiving any information related to this claim prior to the Request for Medical Fee Dispute Resolution . . . As the payments were issued within 60 days of the Carrier's first receipt of the complete medical bill, no interest was due.

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2015, August 19, 2015	Impairment and MMI Evaluation Services	$790.00	$29.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.
4. 28 Texas Administrative Code §129.5 governs the filing of and payment for work status reports.
5. The insurance carrier did not issue copies of explanations of benefits prior to the filing of the request for medical fee dispute resolution. New denial reasons or defenses presented to the requestor in explanations of benefits issued after the filing of the request for MFDR do not meet the requirements of 28 Texas Administrative Code §133.307(d)(2)(F). Any such new denial reasons or defenses have been waived by the respondent, and shall not be considered in this review.

Issues

1. Is this dispute eligible for medical fee dispute resolution?
2. What is the reimbursement for the work status reports billed under code 99080-73-RR?
3. What is the reimbursement for evaluation and management code 99204?
4. What is the reimbursement for division specific code 99456-WP
5. Is the requestor entitled to additional reimbursement?

Findings

1. Review of records held by the division finds no information to support that the insurance carrier has notified the division that the injured employee has been enrolled in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. The response does not include any documentation to support that the injured employee is enrolled in a certified workers' compensation HCN.

   28 Texas Administrative Code §133.240(f)(15) requires that the insurance carrier shall include the "workers' compensation health care network name (if applicable)" on the paper form of an explanation of benefits.

   While the explanation of benefits (which was generated *after* the filing of the request for MFDR) does mention the name "Coventry Integrated Network"—*Coventry Integrated Network* is not *itself* a certified Texas workers' compensation health care network established in accordance with Insurance Code Chapter 1305. *Coventry Integrated Network* is rather a *trademark* under which a variety of different networks (each with separate names) are marketed. "Coventry Integrated Network" is not the name of a specific Texas certified workers' compensation health care network in which a Texas injured worker would be enrolled.

   Without listing the name of the *specific* Texas workers' compensation health care network in which the injured employee is enrolled (if applicable), the insurance carrier has failed to meet the requirements of Rule §133.240(f)(15).

   Moreover, in the absence of any evidence to support that the insurance carrier presented clear information to the health care provider that the injured employee was enrolled in a certified workers' compensation health care network (HCN) *prior* to the filing of a medical fee dispute—whether as a plain language notice on an explanation of benefits issued *before* the filing of a medical fee dispute, or otherwise—the respondent has failed to meet the requirements for raising such a defense.

28 Texas Administrative Code §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

The health care provider requested medical fee dispute resolution on May 18, 2016. The respondent issued an explanation of benefits dated June 10, 2016. This date is *after* the date the request for MFDR was filed.

Consequently, the division finds the carrier has *waived* the right to raise any denial reasons or defenses. Any denial reasons or defenses presented to the requestor on the EOB issued *after* the filing of the request for MFDR do not meet the requirements of Rule §133.307(d)(2)(F) and may not be considered in this review.

As the respondent has not presented any information to the requestor regarding a certified workers' compensation HCN *prior* to the filing of a medical fee dispute, the division concludes the respondent has waived the right to raise such a defense.

Furthermore, the insurance carrier's EOB states: "INSURANCE CARRIER PAYMENT TO THE HEALTH CARE PROVIDER SHALL BE ACCORDING TO DIVISION MEDICAL POLICIES AND FEE GUIDELINES IN EFFECT ON THE DATE (S) OF SERVICE (S)."

Based on the information presented for review, and information known to the division, the division concludes the respondent has failed to support that the injured employee is enrolled in a certified HCN. Moreover, even were the injured employee enrolled in a certified HCN, the insurance carrier has waived the right to raise such a new defense pursuant to §133.307(d)(2)(F).

Labor Code §413.031(a)(1) states that a health care provider is entitled to a review of a medical service provided if a health care provider is "denied payment or paid a reduced amount for the medical service rendered."

Labor Code §413.031(c) further states that "in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules."

The Texas Workers' Compensation Act entitles health care providers to a review of medical services if payment is denied. The Act further grants the division authority to resolve such disputes and adjudicate such payments. For these reasons, the division has jurisdiction to review the disputed medical fee issues.

Review of the submitted information finds that the insurance carrier has issued payment on the disputed services in response to the request for MFDR. The respondent has waived any denial reasons or defenses and the division finds the only remaining disputed issues involve the amount of the fees to be paid. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards, in part, payment for work status reports performed August 3 and August 19, 2015, billed under procedure code 99080-73-RR, with reimbursement subject to the provisions of 28 Texas Administrative Code §129.5(i), which states that "The amount of reimbursement shall be $15." This amount is recommended as payment for each report, for a sum of $30.00.

3. This dispute regards professional medical evaluation and management services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is $56.20.

For evaluation and management code 99204, service date August 3, 2015, the relative value (RVU) for work of 2.43 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 2.47374. The practice expense (PE) RVU of 1.99 multiplied by the PE GPCI of 1.009 is 2.00791. The malpractice RVU of 0.22 multiplied by the malpractice GPCI of 0.772 is 0.16984. The sum of 4.65149 is multiplied by the Division conversion factor of $56.20 for a MAR of $261.41. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $260.80.

4. This dispute further involves a referral examination to evaluate Maximum Medical Improvement (MMI), with reimbursement subject to 28 Texas Administrative Code §134.204(j)(3)(C), which states that "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   Additionally, the dispute involves Impairment Rating (IR) evaluations of musculoskeletal body areas, with reimbursement subject to the provisions of Rule §134.204(j)(4)(D)(v), which states: "The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150."

   This total recommended reimbursement for the MMI evaluation with IR assignment is $500.00.

5. The total allowable reimbursement for the services in dispute is $790.80. The insurance carrier has paid $761.72. The amount due to the requestor is $29.08.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $29.08.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $29.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.